Access to Primary Care Providers in Clark County

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Executive Summary

In Fall 2003 and early 2004 Clark County Health Department, with the support of community partners, surveyed medical practices to determine the amount of direct care provided by primary care physicians in Clark County. This was the first comprehensive provider survey conducted in the county. Information gathered will support community efforts to improve access to healthcare. The data has also been used by the community as a basis for obtaining Federal Health Professional Shortage Area (HPSA) designations. (Additional information on the HPSA process is available in Appendix 2.)

In the context of this survey "access to healthcare" is measured by three factors: physician capacity, population to physician ratios and availability of primary care providers by insurance type or "payer." The following summary highlights key findings about each of those areas.

Physician Capacity
In Clark County, 210 primary care physicians provided care at the time of the survey. After adjusting for part-time hours and hours not in direct patient care, these physicians provided 169.3 full time equivalences (1 FTE = 40 hours of direct patient care/week) of direct patient care.

- Eighty Family Practice physicians accounted for 41% of primary care FTE, 40 Pediatricians accounted for 19%, 55 General Internal Medicine (GIM) physicians accounted for 30% (this is higher than most urban counties compared in this report), 16 OB/GYN physicians account for 8% (this is slightly lower than most urban counties) and 19 Resident Physicians accounted for 2% of FTE (residents hours are computed differently than physicians in practice).
- These primary care physician FTEs are disbursed among a range of clinic types. Forty-three percent are located at multi-specialty private practices, 28% are located in single-specialty private practices, 22% are in HMO organizations, 5% are in residency and 2% are in the community clinic.

Access Ratios
The ratio of provider FTE to population is a measure of the adequacy primary care provider capacity for existing patients. Clark County's ratio of total population to primary care physicians reflects a system approaching stress levels. The ratio of population per 1 FTE (40 hours direct patient care) is 2208:1. While this is better than the federal standards for serious shortage (3000:1), it is worse than ideal capacity levels (1200:1).

- The system serving low income residents shows signs of stress with a ratio of 2691:1 for the population below 200% of the Federal Poverty Level.
- Access to care in the rural areas of Clark County is significantly worse than in the urban areas of the county. The Ridgefield, Yacolt, and La Center areas have no primary care providers. Camas and Battleground have ratios in excess 5000:1 for the general and low income populations. The low-income population has particularly high ratios in Salmon Creek (6121:1). The Salmon Creek area includes Lake Shore, Hazel Dell, Rye and

Minnehaha. This is particular concern as the low-income population has fewer transportation options.

- The population to provider ratio for the population over 65 (generally referred to as the "Medicare population") is 968:1. This is below (or better than) ideal range and may be related to the higher percentage of General Internal Medicine physicians in Clark County. Rural areas of the county have higher ratios for Medicare populations than urban areas (1438:1).

Access by Payer for New Patients

Almost all primary care physicians (91%) are accepting new patients with private or employer-sponsored insurance without restriction. Pediatricians indicate they are less open to new privately insured patients (73%).

Access to physicians is more limited for new patients that are publicly insured.

- New Medicaid Fee for Service (FFS) patients are accepted by 12% of practitioners.
- New Medicaid Healthy Options patients are accepted by 60% (this is significantly higher than most other counties in Washington).
- New Medicare FFS patients are accepted by 22% of providers.
- New Medicare Plus Choice patients are accepted by 76% of primary care providers (again, this is higher than most other counties).
- New Basic Health patients are accepted by 46% of providers.

Access to private physicians for those with Medicare or Medicaid Fee for Service coverage is a major concern. While private physicians provide the majority of primary care for publicly insured patients, fewer than 11% are taking new Medicaid FFS patients and fewer than 20% are taking new Medicare FFS patients without restriction. Restrictions imposed are serious and make access unlikely for most new patients.

Background

The Office of Community and Rural Health, Washington State Department of Health works with local communities to survey primary care providers to assess eligibility for Health Professional Shortage Area (HPSA) status. While HPSA status is voluntary, it establishes eligibility for several federal assistance programs. Federal designation process and benefits are discussed in Appendix 2. These surveys are conducted on a three-year cycle. The survey includes questions such as:

- How much direct care is provided to patients?
- What are relative patient shares for Medicare Fee for Service (FFS) and Medicare Managed Care, Medicaid FFS and Medicaid Managed Care, Basic Health and Sliding Fee Scale?
- Are specific primary care providers taking any new privately insured, Medicare, Medicaid, Basic Health or Sliding Fee Scale patients?

HPSA survey data offer a useful snapshot of access to primary health care, but results should be interpreted with some care. Limitations of this survey data include:

- It covers only access to **primary care** physicians, nurse practitioners and physician assistants (*Family and General Practice, General Internal Medicine, General Pediatrics, and General OB/GYN*). Access to specialty care is a concern if specialists are not accepting referrals for Medicaid or Medicare patients. This in turn may be a factor influencing whether primary care physicians are willing to accept Medicare and Medicaid patients.

- It is self-reported. When possible the survey is administered to the clinic manager who is often more aware of payment systems than are providers. Office of Community and Rural Health spot comparisons of self-reported Medicaid share information from HPSA surveys to activity reported to the Medical Assistance Administration have found that some self-reports over-estimate Medicaid patient shares. Access may be lower than is reported here.

- It does not adjust for differences in the use of primary care specialists by payer. Direct comparisons between Medicaid and Medicare access should be made cautiously. Medicare patients use more specialty care (not included here) and are not likely to be seen by pediatricians (who are included).

<u>Survey Procedures</u>

The Clark County Health Department and Southwest Washington Medical Center compiled a list of all primary care practices in Clark County and identified 210 primary care physicians. The business office of each practice was faxed a letter and survey with instructions and then contacted by phone in the spring of 2004. The response rate for the survey was 97.6% (205 of 210). Non-respondents were all small private practices. The Office of Community and Rural

Health entered the data and made follow-up calls to correct inconsistencies (for example practice shares totaling more than 100%).

Clark County Profile

Over the last ten years Clark County has experienced rapid growth (generally 50% higher than the State average) and an increasingly diverse population. Clark County ranks 5th in population and personal income, but 35th in area among Washington's 39 counties. The largest numbers of residents are employed in the services sector, retail trade and government. In general, employers in services and retail trade are less likely to offer health insurance to their employees.

Clark County is located in Southwestern Washington State across the Columbia River from Portland Oregon (See Map). Primary care infrastructure for Vancouver and Portland are interconnected as there are commuter and travel flows across the state line and some health care providers (for example Kaiser Permanente) have locations in both states. This analysis does not address interstate patient flows and capacity issues (which can go both ways) and we don't have a measure of what direction the net flow of patients is. But it may be likely that some primary care capacity needs for the general population are met by Portland providers which could overstate capacity problems. This is a larger concern for the general population (the employer insured) which is more mobile and is likely to have providers who will accept new patients. According to the Medical Assistance Administration in the Washington Department of Social and Health Services, there is almost no cross border primary care use for Medicaid patients since the state does not contract with Oregon Primary Care Providers.

When analyzing the numbers of primary care FTE available throughout Clark County the county was divided into these areas:

- Vancouver – including the City of Vancouver, Orchards and Walnut Grove;
- Salmon Creek – including Salmon Creek, Lake Shore, Hazel Dell, Rye and Minnehaha;
- Camas – including Camas, Washougal and area north of there;
- Battleground – Battleground and surrounding area;
- Ridgefield, Yacolt & La Center – named communities, surrounding areas and Woodland.

Approximately 80% of primary care FTE is located in the Vancouver area. Three major medical facilities, Southwest Washington Medical Center, Memorial Health Center and the Veteran's Affairs Medical Center, are also located in there. In outlying areas there are small clusters of providers. The Salmon Creek area has 28 Primary Care Physician FTE. In August 2005 Legacy Health Systems will open a 220 bed hospital in Salmon Creek. Battleground has 6 physician FTE and Camas has 3 FTE. There are no primary care providers in the Ridgefield, Yacolt and La Center areas at this time.

Table 1 compares population characteristics, Medicaid and Medicare insurance options, and community health centers and rural health clinics in Clark County to four other Western Washington counties which were surveyed in the last two years. Interestingly, Clark County has a low percentage of senior citizens (9.5%) and a rather high percentage of General Internal Medicine (GIM) physicians (30%). GIM physicians are common primary care provider for seniors. Clark has the highest percentage of pediatricians among the counties compared.

Clark County has a similar number of Healthy Options and Basic Health plans to comparison counties; however Columbia United Providers has unusually high levels of provider participation. This may account for the higher than average percentage of physicians accepting new Medicaid Healthy Options patients.

Table 1
Demographic and health care services statistics for comparison counties

County	2003 Population[i]	% Below 200% of FPL (2000)	% Over Age 65 est. (2003)[ii]	# of Primary Care Providers (% Pediatricians)	# Healthy Options Plans	# Medicare+ Choice Plans (# Enrolled (03))***	# of BH** Plans	FQHC* Clinics (Share of primary care FTE)	Rural Health Clinics/Tribal Health Centers
Kitsap	237,000	24%	10.9%	117 (9%)	3	1 (3347)	2	1 (6%)	0
Skagit	106,700	28%	14.6%	97 (19%)	3	1 (3766)	2	1 (8%)	7 (56%)
Clark	372,300	24%	9.5%	210 (19%)	2	2 (15,468)	3	1 (2%)	0
Whatcom	174,500	30%	11.9%	113 (15%)	3	2 (3271)	2	2 (12%)	0 (0%)
Thurston	214,800	23%	11.6%	160 (NA)	2	2 (8819)	2	1 (2%)	2 (outlying) (1%)

* Federally Qualified Health Center
** BH – Basic Health
*** Number of active plans with > 100 enrollees

The Safety Net in Clark County

Traditionally the term "safety net" has been used to describe the component of the healthcare system serving low-income and uninsured people. Safety net clinics have a legal mandate or expressly adopted mission to serve all patients, regardless of ability to pay. Federally Qualified Health Centers (which receive federal grant funding to serve the uninsured) and Free Clinics or "charity" clinics are the most common.

In addition to the community and free clinics that have a legal mandate or expressly adopted mission to serve all patients, regardless of ability to pay, there is the *auxiliary safety net*. This class of providers and clinics plays an essential supporting role. Although auxiliary safety net

providers are not subject to explicit mandates and missions, they may receive some direct or indirect public support and are more likely to serve enrollees in Medicare and Medicaid and the uninsured population than are most private practices. This category includes, but is not limited to, rural health clinics, residency programs and tribal health centers.[iii] For the remainder of this report the term "safety net" will be used to refer to both the primary and auxiliary safety net clinics.

As noted in Table 1, Clark County has a very limited safety net. It includes one Community Health Center (with 2% of primary care FTE in the county) and no Rural Health Clinics or Tribal Health Centers. The residency program, with 5% of primary care capacity, is an important component in the county's safety net. The Healthy Steps Women and Children's Center, while not a designated part of the safety net, also serves an important role providing obstetric and gynecological services to many women who are publicly insured. Four of the eight physicians on staff are OB/GYN specialists. This is especially noteworthy considering that neither the Community Health Center, nor the Residency program, have OB/GYN providers.

Additionally, there are two Free Clinics in Vancouver.

1. The Free Clinic of Southwest Washington provides basic urgent care to uninsured patients. It is a 1-time service with referrals out for those needing continuing care. It does not provide primary care and therefore its care capacity is not included in this report.
2. New Heights Clinic operates with a very small administrative staff and more than 140 volunteer healthcare professionals. It provides ongoing primary care to over 100 uninsured patients each month. The clinic is open approximately 14 hours per week, serving patients at various hours of the day and evening. The clinic's primary care capacity is roughly .3 FTE.

Primary Care Providers in Clark County

As of early 2004, 210 primary care physicians provided 169.3 FTE of direct patient care. Direct patient care excludes specialty care, administrative, and on-call, but includes hospital rounds and urgent care. Table 2 summarizes primary care headcounts and FTE by primary care specialty. Family Practice providers accounted for 41% of primary care FTE (80 physicians), Pediatricians 19% (40 physicians), General Internal Medicine providers 30% (55 physicians), and OB/GYN 8% (16 physicians).

In addition, we identified 64 mid-level providers, 25 of who are Nurse Practitioners, 28 are Physician Assistants and 11 are Certified Nurse Midwives. Table 3 identifies the specialty areas of the 64 mid-levels. Unfortunately, FTE information is not available for mid-level providers. Mid-levels are present in all clinic types. Twenty-Five mid-level practitioners are in single-specialty clinics, 20 in multi-specialty clinics, 18 in HMOs and 1 in the Community Health Center.

Table 2
Primary Care Physicians
Clark County, Washington – March 2004

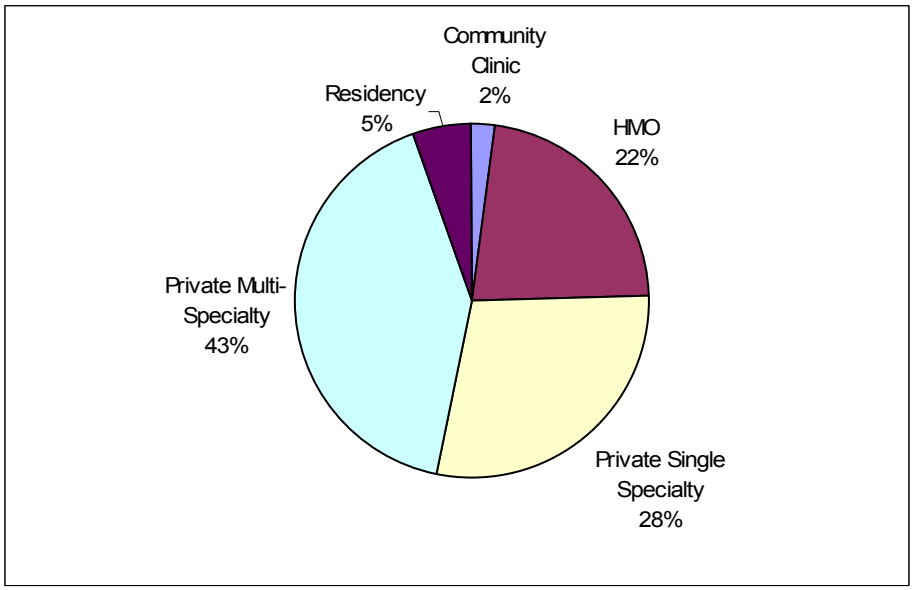
Physicians by Specialty	Headcount	FTE
Family Practice	80	68.6
Pediatrics	40	32.7
OB/GYN	16	13.7
GIM	55	50.6
Residents	19	3.7
Total Physician Primary Care	**210**	**169.33**

Table 3
Primary Care Mid-Level Providers
Clark County, Washington – March 2004

Mid-Level Providers by Specialty	Headcount		Mid-Level Providers by Type	Headcount
Family Practice/GP	37		Nurse Practitioner	25
Pediatrics	4		Physicians Assistants	28
OB/GYN	20		Certified Nurse Midwives	11
GIM	3			
Total Mid-Level Primary Care	**64**		**Total Mid-Level Primary Care**	**64**

Ninety-three percent of all primary care physicians FTE is located at private practices, including multi-specialty (43%), single-specialty (28%) and HMO (22%) practices. Only 2% of FTE is located at the community health center. The residency program at Family Medicine of Southwest Washington, with 5% of primary care capacity, is also an important component in the healthcare safety net.

Figure 1
Primary Care FTE by Clinic Type
Clark County, Washington – March 2004 (N=169.3 FTE)



Access to Primary Care Physicians

System Showing Stress for the General and Low-Income Population; Access is a Serious Concern in Rural Areas

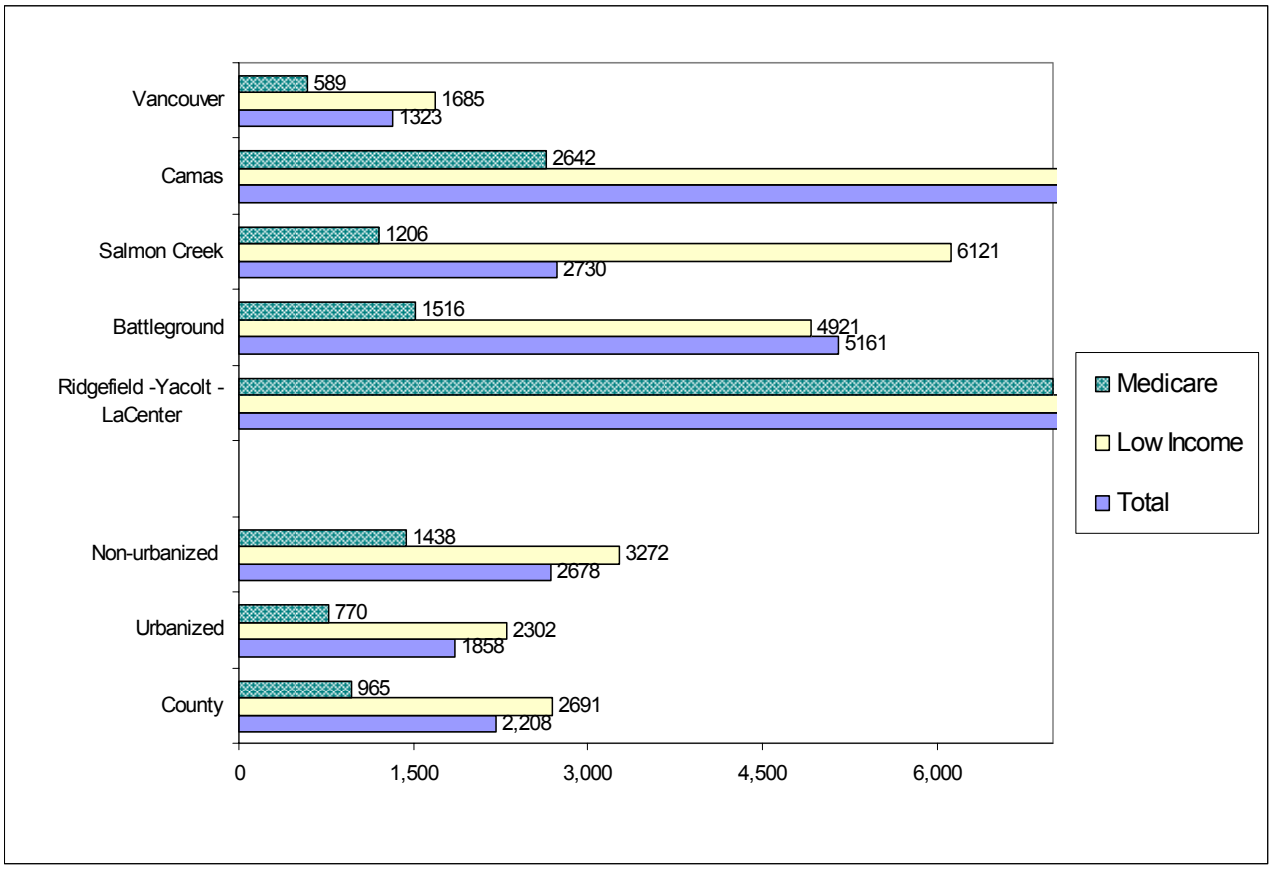
As shown in Figure 2, population to provider FTE ratios in Clark County indicate primary care capacity for the total population (with a ratio of 2208:1) and low-income population (2691:1) is showing signs of stress. The low-income population includes residents with incomes below 200% of the Federal Poverty Level and the homeless. Low-income capacity is measured by primary care physician FTE shares covered by Medicaid, Basic Health and posted sliding fee scale. The ratio of the population over 65 to Medicare physician FTE (965:1) is well within the range found when all persons are insured.

Access is not uniform across the county. The Vancouver area (including Orchards & Walnut Grove) has population to physician ratios at low (good) levels, while Camas and Battleground area ratios indicate serious shortages, especially for low-income populations. There are *no providers* in the Ridgefield, Yacolt or La Center areas at this time. Low-income populations in

non-urbanized or rural areas face serious physician shortages (3272:1). The Salmon Creek area (including Lake Shore, Hazel Dell, Rye and Minnehaha) has significant access concerns for the low income population.

With advent of the new Legacy Health System Hospital in Salmon Creek access for the overall population may improve. The recent conversion of the Woodland Clinic to Federally Qualified Health Center status may provide an important new access point for the low income population in North Clark County. Nonetheless access to care for Medicare, Medicaid, and uninsured patients remains a serious concern in the rural areas of counties because of limited transportation options. Already limited public transportation options will be further limited in September 2005, if C-TRAN implements it service reduction plan which eliminates most routes in the outlying areas of the county.

Figure 2
Population to Provider Ratios
Clark County, Washington – March 2004



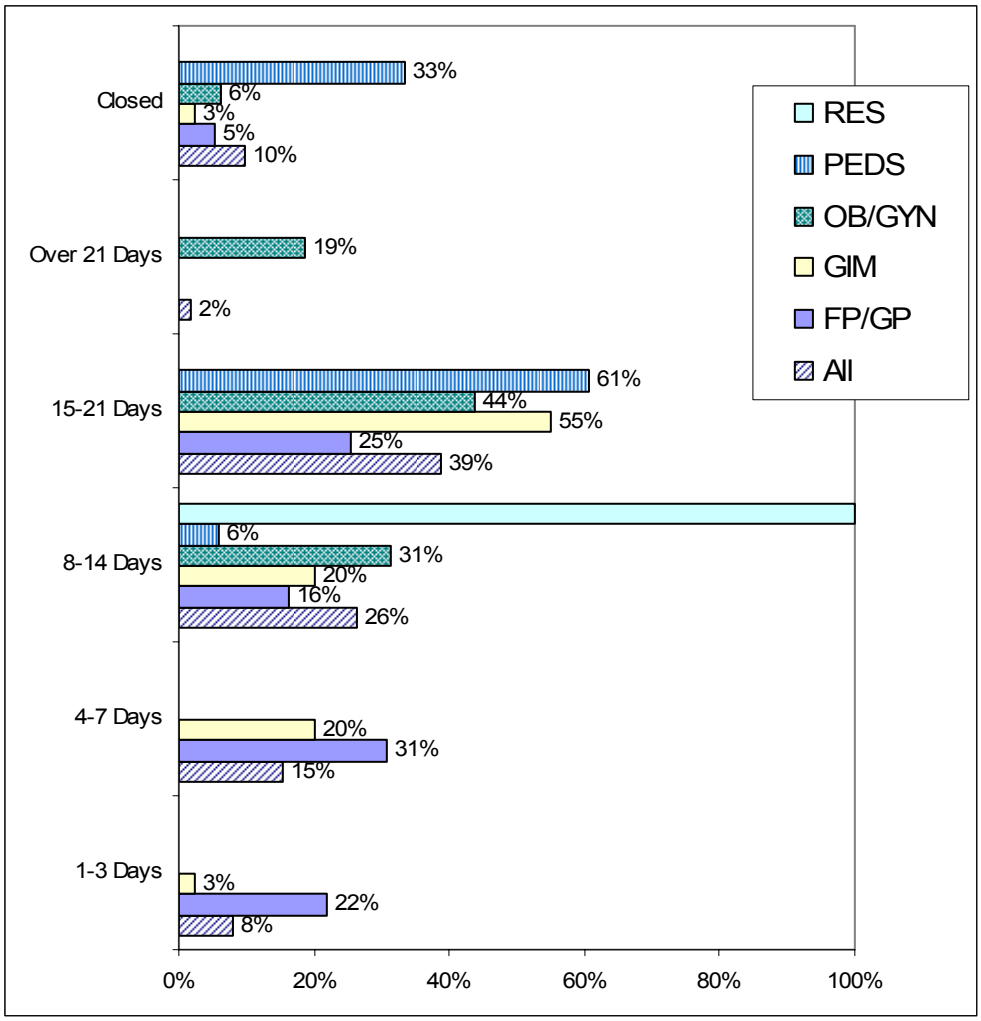
Adequate primary care physician capacity is measured by the ratio of provider FTE to the population. This is a crude measure that is not adjusted for case mix complexity and provider productivity. The ideal ratio assuming everyone is insured or could afford care is between 1:1000 and 1:1500. This level is based on typical staffing ratios found in managed care organizations. Typical ranges found in larger cities and towns are between 1:1200 and 1:1800. The criterion for

Federal Health Professional Shortage Area designations is 1:3000. Ratios over 1:2000 indicate some degree of stress.

Days to First Appointment

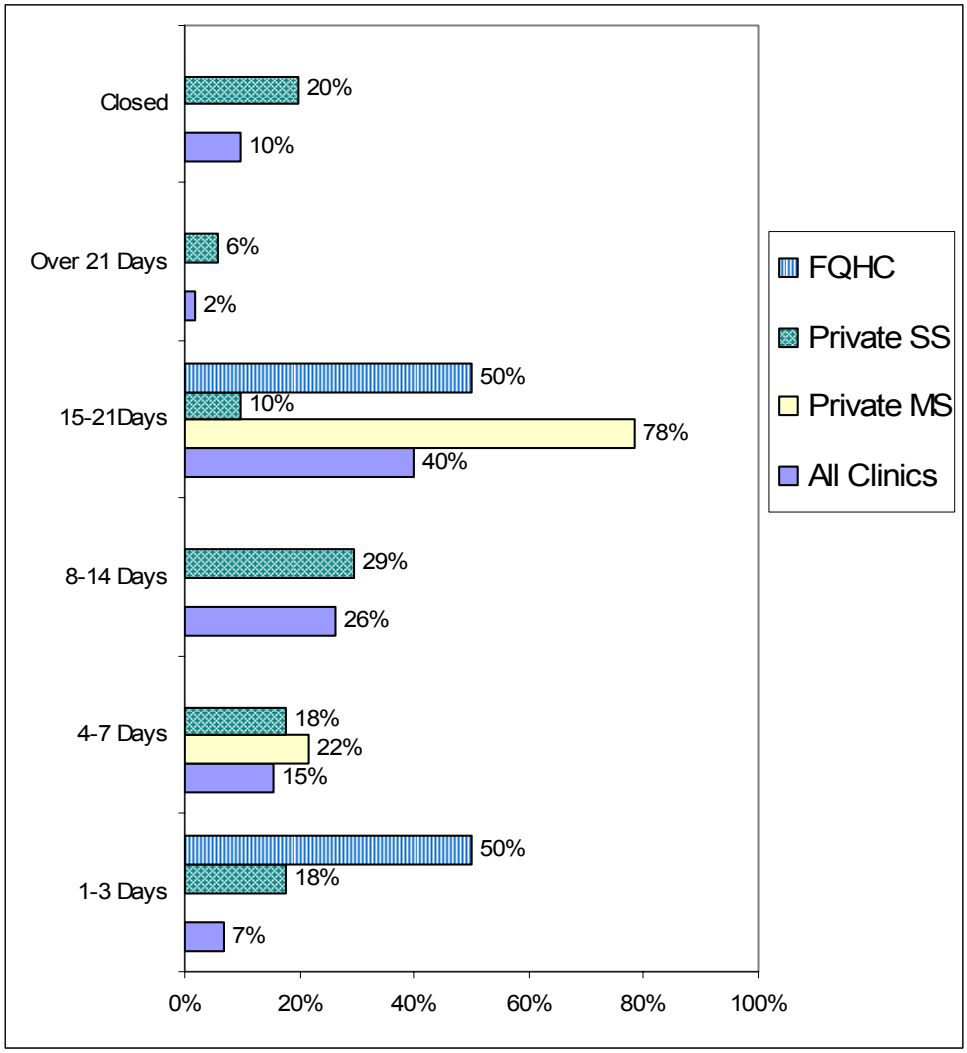
Delays in scheduling new patients with non-emergent conditions show initial indications of limited access to primary care physicians. The situation is particularly serious for Pediatric and Obstetric patients. Sixty-one percent of pediatric physicians have wait times of 2-3 weeks and 33% are closed to all new patients. Similarly, 55% of OB/GYN physicians have waits of 15-21 days and 19% have waits over three weeks. Wait times for these specialists are similar in other urban counties. Among Family Practice physicians 53% have wait times of 1-7 days. The wait time for residency physicians is 8-14 days. Ten percent of all physicians surveyed are closed to new patients.

Figure 3
Delays in Scheduling New Patient Appointments by Primary Care Physician Specialty
Clark County, Washington - March 2004



When examining physician wait times by clinic type (Figure 4) we find 20% of physicians in single specialty practices are closed to new patients and six percent have wait times of over three weeks. The high percentage (78%) of physicians in multi-specialty practices with 15-21 day waits is probably a reflection of the longer wait times typical for specialists. The Community Health Center has a scheduling system that allows sick patients access to same-day care. New CHC patients without a need for immediate care are scheduled out 2-3 weeks.

Figure 4
Physician Wait Times for New Patients by Clinic Type
Clark County, Washington - March 2004



Access by Payer Type

In Contrast to Privately Insured Patients, Few Private Physicians Accepting New Medicaid or Medicare Fee for Service Patients.

Ninety-one percent (91%) of all primary care physicians reported they were accepting new patients with private or employer-sponsored insurance without restriction. As shown in Table 4, new Medicaid Fee for Service patients are accepted by only 12% of practitioners. New Medicare Fee for service patients are accepted by 22%. These percentages are similar to those of other urban counties.

An unusually high percentage of physicians reported they were accepting new patients with Medicare managed care (76%), Medicaid Healthy Options (60%). New Basic Health patients are accepted by 46% of all physicians. (See Figure 7 for a comparison of Clark County private physicians to those in other urban counties.)

Access to specialist primary care providers is a particular concern for new Medicaid FFS patients. Only 5% of Pediatricians, 6% of GIM, 19% of Family Practice and 25% of OB/GYN physicians are accepting new Medicaid FFS patients. New Medicare FFS patients are accepted by only 19% of GIM, 6% of OB/GYN and 39% of Family Practice physicians. The lack of pediatricians accepting Medicare FFS is likely due to their specialization. Sliding Fee Scale (often uninsured) patients are accepted by only 5% of Pediatricians, 15% of GIM, 25% of OB/GYN, and 16% of Family Practice physicians.

Table 4
Percent of Primary Care Physicians Accepting New Patients by Payer, Specialty Type
Clark County, Washington - March 2004 (N=185*)

	All	Family Practice	Pediatrics	OB/GYN	Gen Internal Medicine
Insured	91%	96%	73%	94%	98%
Medicaid FFS	12%	19%	5%	25%	6%
Medicaid HO	60%	57%	55%	69%	65%
Medicare FFS	22%	39%	0%	6%	19%
Medicare MC	76%	77%	68%	44%	89%
Basic Health	46%	25%	55%	75%	61%
SFS	14%	16%	5%	25%	15%

* Does not include physicians in residency program.

Access for New Patients by Clinic Type

Practitioners at the Community Health Center (FQHC) and Residency program are the most accessible to new publicly insured patients. As shown in Table 5, 100% of CHC practitioners are open to new patients with Medicaid FFS, Medicare FFS and BH. Similarly, 100% of practitioners in the Residency Program are open to all payer types, except Basic Health. There are *no OB/GYN practitioners or Pediatricians at the Community Health Center or Residency Program.* Therefore it is likely that new Fee for Service Medicaid and Medicare patients have a difficult time accessing those specialists.

New publicly insured patients have limited options with single-specialty private clinics, where less than half accept Medicaid or Medicare. Again, a sharp distinction exists between physicians open to FFS and managed care Medicaid and Medicare. All providers (100%) in private multi-specialty clinics report being open to new Medicare managed care and Medicaid Healthy Options patients.

Table 5
Percent of Providers Accepting New Patients Without Restriction by Clinic Type & Payer
Clark County, Washington - March 2004 (N=204)

	FQHC	Private – Multi- Specialty	Private – Single Specialty	Residency
Insured	100%	100%	80%	100%
Medicaid FFS	100%	0%	20%	100%
Medicaid HO	100%	100%	47%	100%
Medicare FFS	100%	22%	22%	100%
Medicare MC	0%	100%	31%	100%
Basic Health	100%	78%	47%	0%
Sliding Fee Scale	100%	18%	25%	0%

Practice Shares by Payer

Table 6 illustrates the range of payer (insurance) shares for various clinic types. The Community Health Center (FQHC) reports approximately 98% of its revenue come from a combination of Medicaid (HO and FFS) and Medicare Fee for Service, Basic Health and Sliding Fee Scale patients. The CHC takes, by far, the largest percentage of Sliding Fee Scale patients (33%). The Residency program also takes a large share of public payers, with 80% coming from Medicaid FFS, Medicaid HO and Medicare+ Choice. Private practices in Clark County, are made up of 50-60% privately insurance patients. Reflecting the higher percentages of physicians open to new Medicaid Healthy Options and Medicare managed care patients, private multi-specialty and private single specialty clinics have a larger percentage of publicly insured patients than most urban counties.

Table 6
Physician Practice Share by Payer and Clinic Type
Clark County, Washington – March 2004

	All Clinics	FQHC	HMO*	Single-Specialty-Private	Multi-Specialty-Private	Residency
Medicaid FFS	5%	19%	0%	7%	4%	20%
Medicaid HO	10%	19%	1%	12%	11%	30%
Medicare FFS	11%	2%	0%	13%	12%	30%
Medicare+ Choice	11%	2%	12%	3%	18%	2%
BH	3%	24%	0%	4%	2%	2%
SFS/Uncompensated	1%	33%	0%	1%	0%	2%
Insured/other	59%	2%	86%	60%	52%	14%

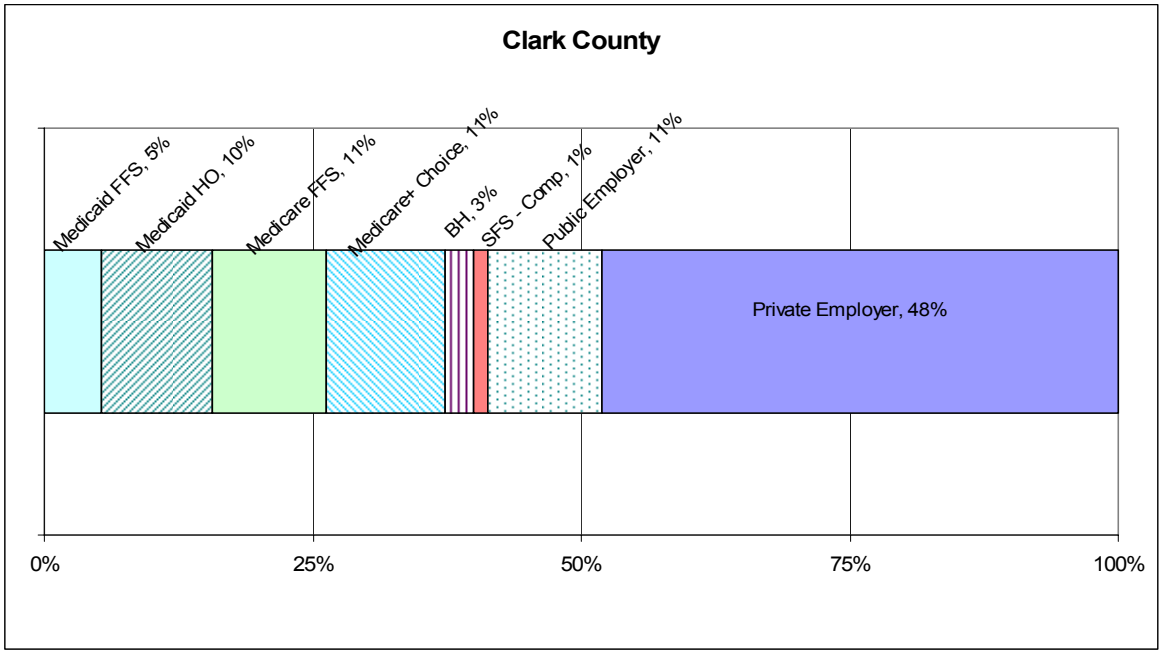
* HMO payer shares are listed as reported in survey results. These percentages may or may not include some Basic Health shares.

Health Care System Financing

Clark County--A Tax Financed System

Tax expenditures are the largest health care payment source in all areas of the country. In 1998, 51% of national health expenditures were tax financed, 27% were private-employer financed, and 22% were paid directly out-of-pocket.[iv] The chart on the following page summarizes patient shares by payment source adjusted for FTE. In Clark County, 52% of primary health care patients are completely or partially tax financed through Medicare, Medicaid, or insurance offered to federal, state and local government employees (including military personnel) or their dependents. This rate is an underestimate of the share of total health care expenditures that are tax financed. Not accounted for are "hidden" publicly financed health care expenditures such as health care expenditures for those in prisons and jails, and the fact that Medicare covers an even larger share of hospitalization costs than private insurers.

Figure 5
Percent Total Primary Care Physician FTE by Payer
Clark County, Washington – March 2004



The proportion of those insured as employees or as dependents of federal, state and local government employees was estimated using 2000 Labor Market Employment Analysis branch county industry employment data.[v] This was adjusted to reflect health insurance rates by industry using an approach developed by Bunting (2001), for estimating county health insurance rates.[vi] According to the 2000 Washington State Population Survey, 93% of government employees had health insurance available to them. In contrast, 54% of workers in businesses with 10 or fewer workers have access to insurance.[vii] The estimates of the relative share of employer insured patients who are public employees reported here might be underestimates as the industry health insurance rates were developed from national and state studies.

Public payer share in Clark County (41%) is similar to other urban counties. Public payer share includes Medicare, Medicaid, BH and posted (compensated) Sliding Fee Scale patients. This percentage excludes those insured as public employees. Comparatively, Thurston County public payer share is 40%, Spokane's is over 50% and rural areas are generally about 60%.

Historical trends

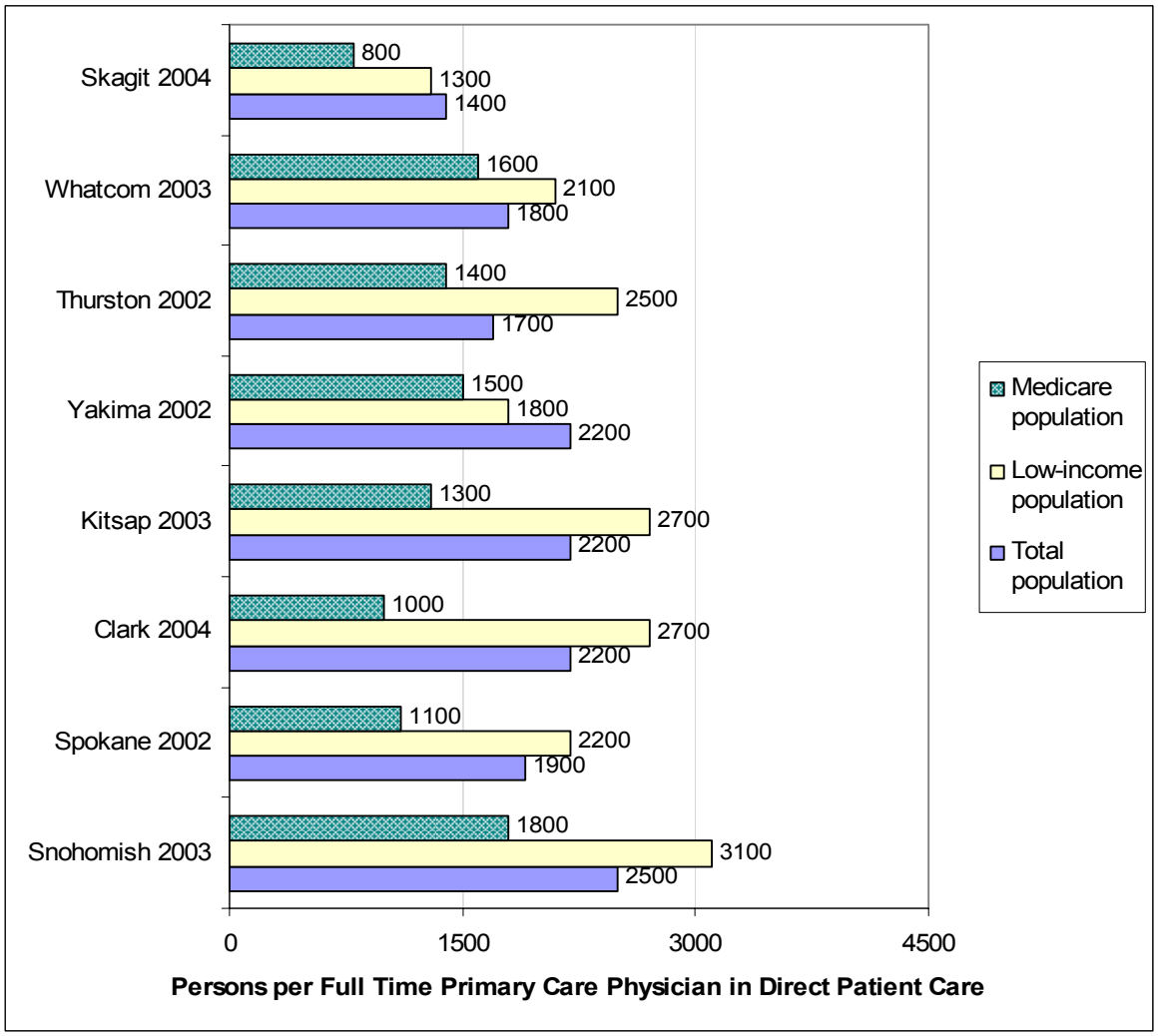
Between 2000 and 2004, Clark County's population increased by 11.02% compared with a statewide increase of 4.64%.[viii] Since this is the first comprehensive provider survey conducted in Clark County we do not have historical data. In the urban counties in Washington where we

have comparison data, the total number and/or FTE of direct patient care declined or were unchanged from 2004/2003 and 2001/2000. Even if Clark County has not lost primary care capacity over the last five years – increasing population demand places more stress on capacity. But we have not been able to document a massive flight of primary care providers. The data we have available suggests the typical pattern is one of a slow erosion of provider capacity relative to demand.

How Does Clark County Compare to Other Recently Surveyed Urban Counties?

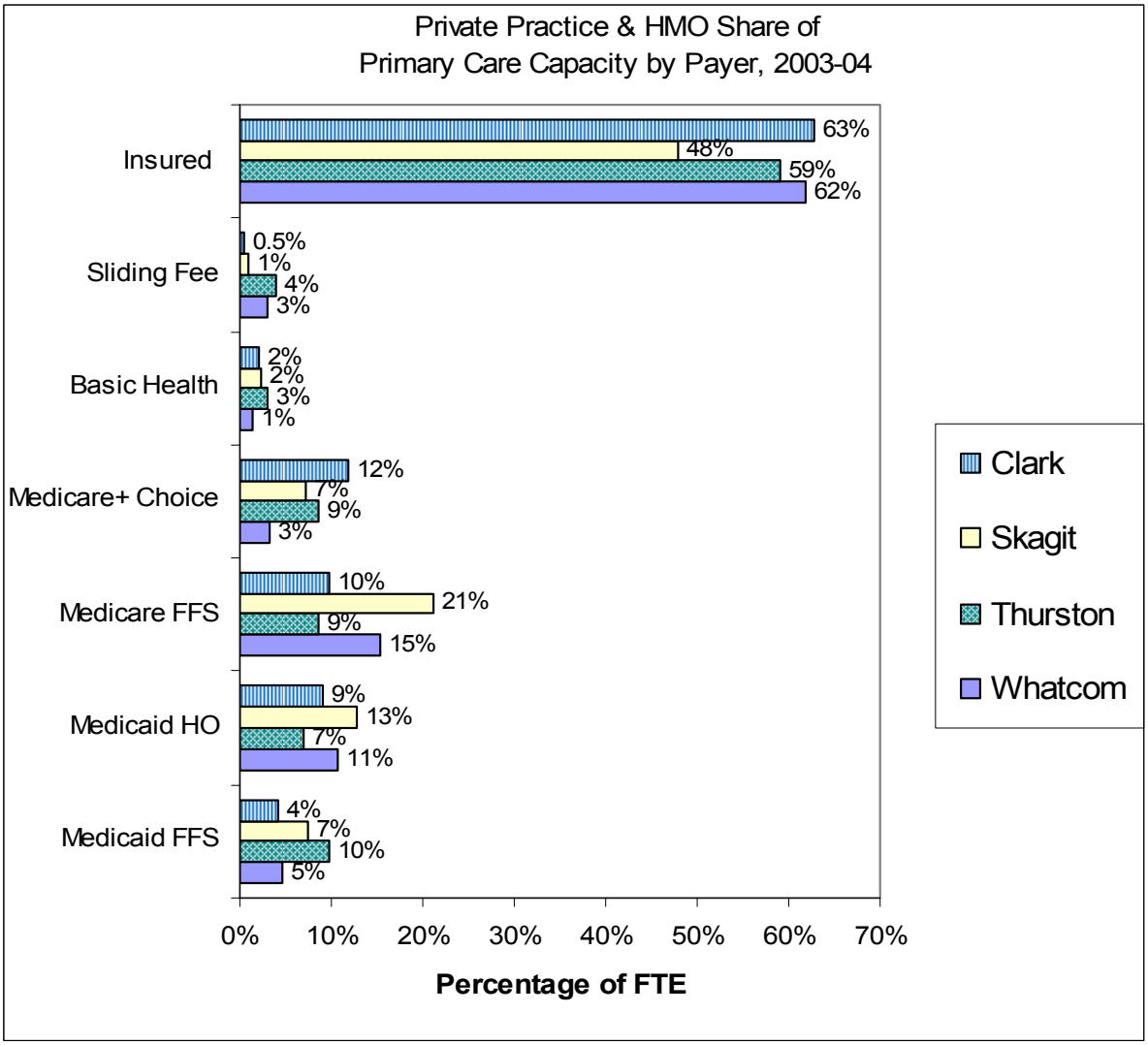
Clark County total population access ratios show initial signs of stress – a pattern common for the urban counties we have surveyed. Clark County has one of the lowest ratios of primary care physician capacity to seniors, 1000:1. This is at or better than benchmarks for ideal capacity levels. On the other hand, Clark County has one of the highest (poorest) ratios of provider capacity to low-income population (2700:1). Low-income ratios for most counties are over 2000:1, which suggests stress on access. Yakima and Skagit County are the exceptions (due to their strong Community Health Center and Rural Health Clinic systems).

Figure 6
Population to Primary Care Physician FTE Ratios Rounded to the Nearest 100th.
Selected Washington Counties (Listed in order of Population) 2002 –2004



Clark County is unique among urban counties in that the percentages of providers open to new patients with Medicare MC, Medicaid HO or Basic Health are several times higher. However, the percentages of new Fee for Service Medicare and Medicaid patients accepted in Clark County is similar to or lower than most counties compared.

Figure 7
Availability of Private Primary Care Physicians to New Patients By Payer
Selected Washington Counties, 2003-04



While the percentage of physicians who report accepting public managed care patients is high in Clark County, the payer shares of private physicians indicate the actual capacity they contribute to serving publicly insured patients (37%) is only slightly higher than private physicians contribute in Snohomish (27%) and Whatcom (36%) counties and lower than that reported in Skagit County. The proportion of private physician capacity in Clark County serving the Medicaid population is lower than other counties.

Figure 8
Private Practice & HMO Share of Primary Care Capacity by Payer
Selected Washington Counties, 2003-04

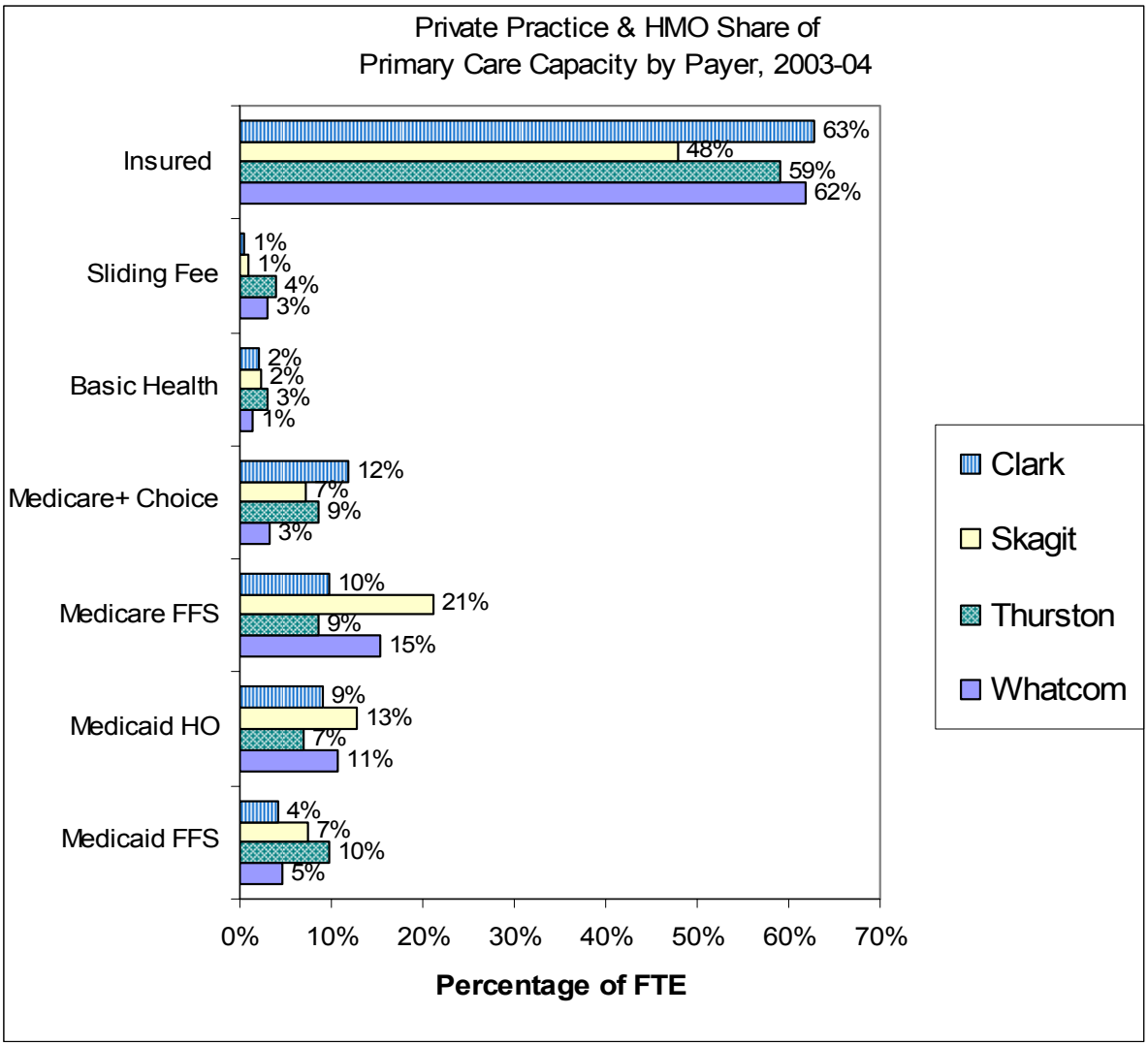
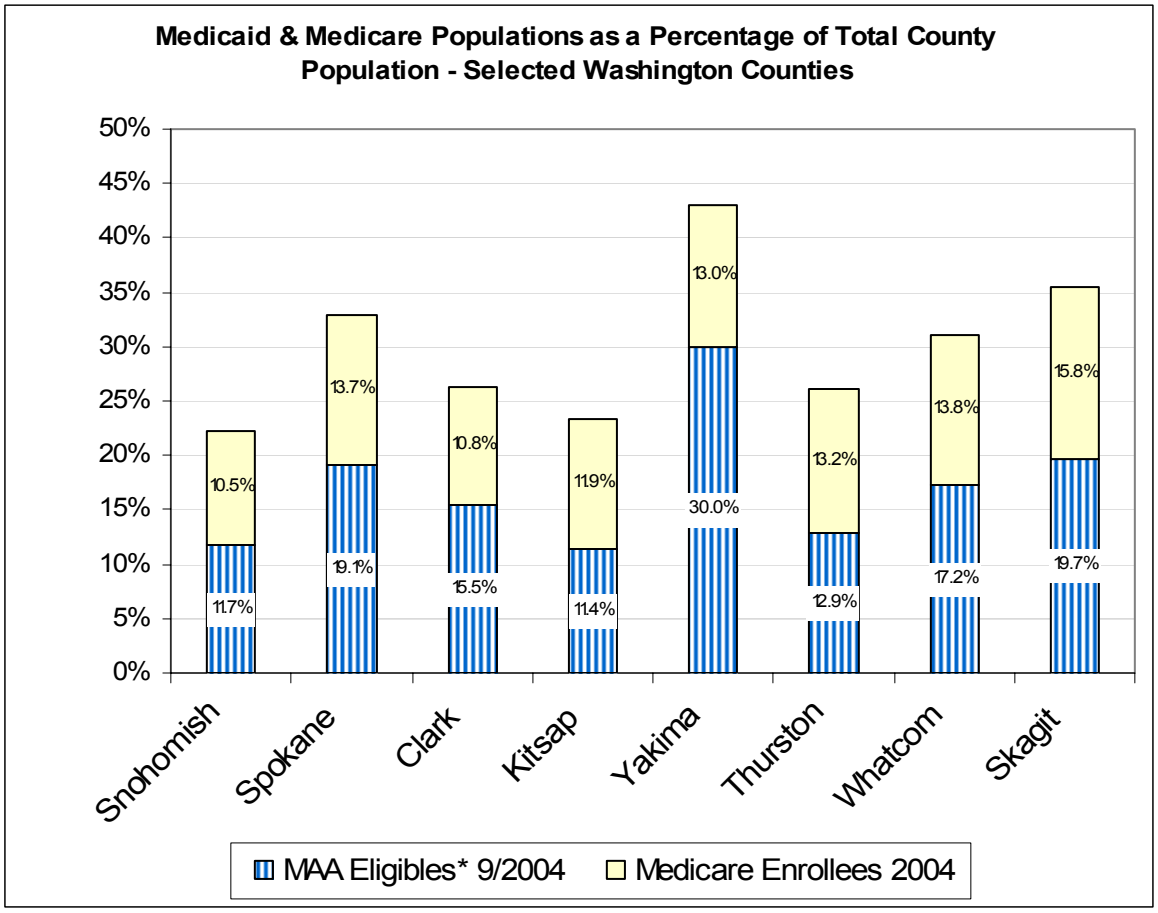


Figure 9 partially reflects Clark County's relatively low percentage of population receiving Medicaid and Medicare benefits compared to other counties. With 15.5% of the population eligible for Medicaid benefits Clark County ranks as the 17th lowest among the 39 counties[ix]. Clark County's low percentage of seniors is evident in its percentage of Medicare enrollees (10.8%).[x]

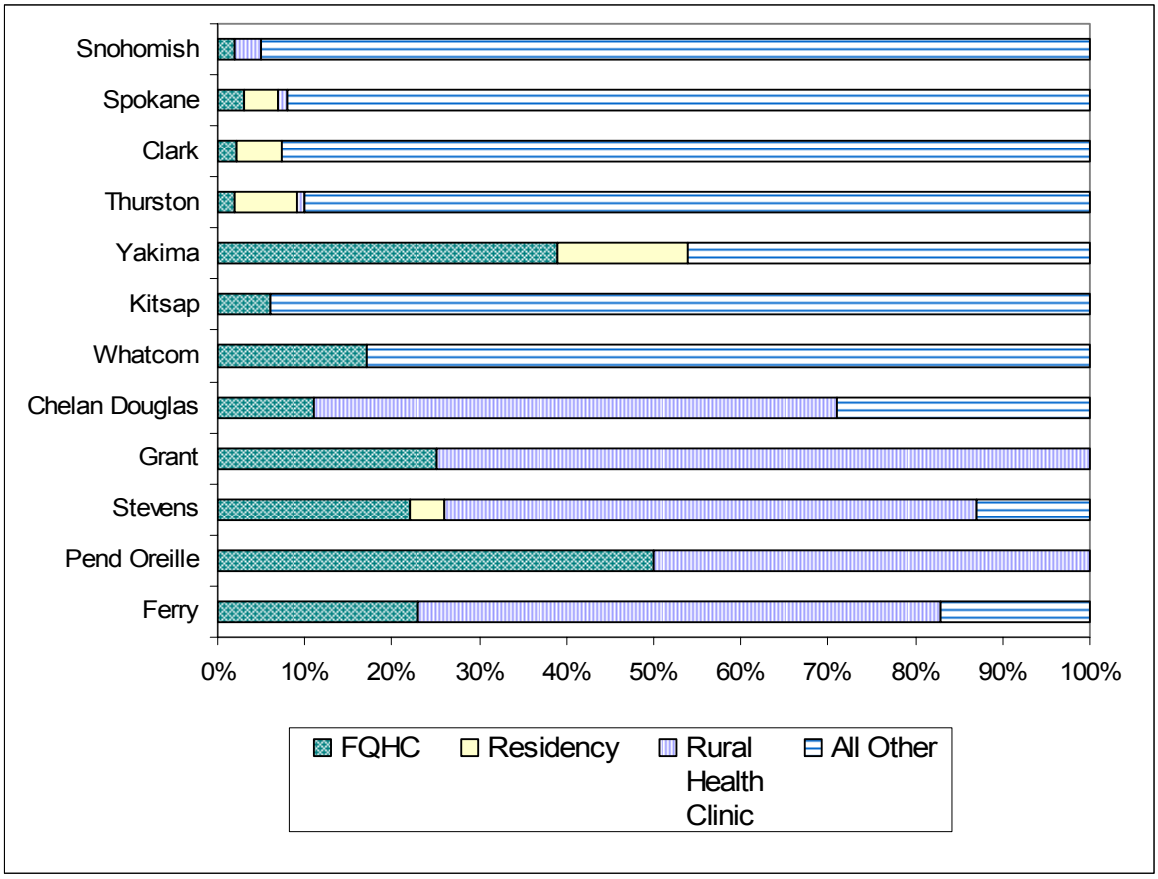
Figure 9
Populations Eligible for MAA & Enrolled in Medicare
Selected Washington Counties, 2004



*"MAA Eligibles" include individuals eligible for Medicaid programs, as well as a small number of individuals dually eligible for Medicaid/Medicare.

Figure 10 illustrates the percentage of primary care FTE available in community health centers (FCHC), residency programs, rural health clinics and all other clinics (mostly private clinics) in several Washington counties. Clark County reflects a lower percentage of FTE in the community health center than most other urban counties. However, the residency program also serves an important role in the safety net.

Figure 10
Percentage of Primary Care FTE by Clinic Type
Selected Washington Counties – 2002-2004



Summary

Primary care capacity available for the total population of Clark County (2208:1) and the low-income population (2691:1) are at the stress point. Measures of access for the Medicare population (964:1) are at ideal levels, within the range found when all persons are insured. Access to care in outlying areas is a serious concern. There are no providers in the Ridgefield, Yacolt or La Center areas at this time. Low-income populations in non-urbanized or rural areas face serious physician shortages (3272:1). The Salmon Creek area has significant access concerns for the low-income population (6121:1).

In Clark County a large than average percentage of physicians are accepting Medicaid Healthy Options and Medicare Plus Choice, however access for new Medicare Fee for Service and Medicaid Fee for Service patients is a concern. Less than 11% of private primary care physicians reported they were accepting new Medicaid FFS patients without restriction. Fewer than 20% of primary care physicians were accepting Medicare FFS

For more information on primary care access issues and activities in Clark County contact:

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Appendix 1: Overview of Medicare, Medicaid and Basic Health

This overview is extracted from the Introduction to Health Care Services section of the Health of Washington State, 2002 and updated in 2004.[xi]

Medicare. This federally funded program primarily for people 65 and older provided health insurance to 811,000 Washington enrollees in 2004. Medicare provides coverage for hospitalization (Part A), physician services (Part B,) and some long-term care. It does not currently cover prescription drugs, preventive services, and selected other health services. Consequently, 43% of Medicare beneficiaries in the 2000 Washington State Population Survey reported they had policies that supplement Medicare coverage. In March 2004, 15.9% of Medicare enrollees in Washington were enrolled in Medicare+ Choice, Medicare's managed care option, a decline from 20.9% in 2001[xii]. Medicare managed care options in rural areas are limited. Consequently, only 10% of Medicare enrollees in Washington's non- metropolitan counties are enrolled in Medicare+ Choice plans in 2004.

Medicaid. This state-federal health insurance program for low-income people covered 950,000 Washington residents in Fiscal Year 2003. Medicaid primarily covers people currently and formerly on public assistance with family incomes within 200% of the federal poverty line, including Temporary Assistance to Needy Families (TANF), and people with disabilities. Children who are not eligible for TANF but have family incomes within 250% of the federal poverty line can enroll in Medicaid through the State Children's Health Insurance Program (SCHIP). About 29% of Medicaid payments are processed through Healthy Options, Washington's Medicaid managed care option. Welfare reform, which moved thousands of Washington families off public assistance, caused a 2.4% drop in Medicaid participation from 1997 to 1999. More recently, enrollment has been increasing as a result of the state's faltering economy, an increase in households unable to cover extraordinary health costs, and implementation of SCHIP. This increase has occurred despite difficult decisions to tighten eligibility criteria and shift non-residents from Medicaid to Basic Health. For a more detailed overview of Washington's Medicaid program see the Department of Social and Health Services 2003 report Facing the Future.

Basic Health (BH). The BH program is administered by the Washington State Health Care Authority to provide subsidized health insurance to low-income individuals who do not qualify for Medicare. In 2000, more than 217,000 state residents received coverage through the BH program or Basic Health Plus (BHP), for Medicaid children enrolled in BH. During the 1990s, the program offered Washington residents a chance to purchase unsubsidized insurance coverage through the BHP. This unsubsidized option is no longer offered, and fewer than 1,000 people remain under this coverage. Subsidized BH coverage was capped at 131,250 in 2000, and the cap was lowered to 125,000 in 2001.[xiii] An additional 56,000 children were enrolled in BHP in December 2001. With passage of Initiative 773 in 2001, funding was made available for an additional 20,000 to 30,000 BH enrollees. Subsequent legislation allowed this additional funding to be used to cover the costs of existing Basic Health members. Basic Health enrollment declined to 118,000 in 2003 and is still dropping.

Appendix 2: Health Professional Shortage Area Analysis for Clark County

Background:

The Federal Health Professional Shortage Area (HPSA) designation establishes eligibility for over 30 federal programs and enhanced Medicare and Medicaid reimbursement amounting to well over $150 million a year in Washington. The designation system, administered by the Shortage Designation Branch of the Bureau of Health Professions was established in 1970's to identify areas of greatest need for placing National Health Service Corps. Over time several other federal programs and reimbursement enhancements, which the HPSA system was not designed for, adopted the system as means of establishing eligibility. The programs and designation requirements sometimes conflict – how an area is designated (and often there are multiple designation options) affects what resources an area is eligible and which providers benefit. For more information on the HPSA System see
http://www.doh.wa.gov/hsqa/ocrh/HPSA/hpsa1.htm

Because of the complexity and potential impacts of designations, OCRH conducts an analysis of designation options (see below) and encourages our local partners to bring all those who might be affected by the designation to the table for education and to provide consensus (if possible and needed) on what the appropriate designation strategy is for the community.

HPSA designation is an administrative process, with proscribed rules governing the data used, calculations and formulas, and thresholds for determining whether there are access concerns. Designation methods are not well suited to the geography of the West. Consequently OCRH does not recommend using the HPSA system to as a systematic means of measuring access to health care. Therefore there may be fairly significant differences between the findings of the assessment and designation results. The assessment of designation options used preliminary data to gauge what was likely to be possible; the actual designation submission differs since it reflects "cleaned" data.

History:

OCRH presented initial findings to stakeholders at a meeting arranged and organized by the Clark County Health Department on July 26, 2004. Designation options for outlying areas (described below) were straight forward. But their were two possible options for designating parts of downtown Vancouver -- creating a small designation limited to the highest poverty areas or a larger designation which included more moderate poverty areas. The Clark County Health Department invited community members to a forum on August 31, 2004.

As a result of that meeting and community input the Health Department elected to move forward with the more expansive downtown designations.

The Office of Community and Rural Health completed HPSA designation requests in October 2004 and submitted them to the Shortage Designation Branch in the Federal Bureau of Health Professions. The federal review process takes 8 to 12 months. A final determination is expected by summer 2005

HPSA Options for Clark County

Prepared: August, 2004

General Findings:

Total Primary Care Physician headcount: 202
Total Primary Care Physician FTE: 164 FTE
Total Primary Care HPSA FTE: 162.5 (excludes NHSC)

Unadjusted County ratios:

Total population per FTE: 2273
Low income population: 3061

HPSA adjustments:

- Excludes National Health Service Corps physicians
- Basic health FTE not included in Low Income
- Rounding adjustments

Key Constraints from Federal Rules

- Counties with large metropolitan areas (>250,000) can not be designated in their entirety
- The designation threshold for total population (Geographic) HPSA designation is quite high -- >3500:1
- Low income designations require high poverty concentrations (more than 30% over 200% of the Federal poverty level
- Must rule out access in areas within 30 minutes travel time (25 road miles). This based on capacity serving the population – NOT whether providers are accepting patients. In cases of very high poverty >20% below 100% of FPL can use bus transportation times.

Current Primary Care HPSA Designations in Clark County

HPSA Name	Type	Ratio	Expiration
Battleground	Low-Income	6025:1	10/31/2004
Camas	Low- income	13602:1	10/31/2004
Downtown – Hazel Dell	Low - Income	11321:1	10/31/2004

Key Findings from HPSA Analysis

1. Although Low-income ratio Clark County exceeds the HPSA designation criteria for the low-income population, it is to populous and county wide poverty levels are too low to qualify for a county-wide designation.

2. The Battleground-Orchards Area is no longer eligible for a low-income HPSA, largely because the area no longer meets poverty concentration requirements. Only one census tract in this area has more than 30% under 200% of FPL. We can not designate this tract because too many providers are located there.

3. It is likely we will be able to re-designate the Camas Area for the Low-Income population. The ratio of the proposed updated designation would drop from 13602:1 to 12500:1. This area also meets requirements for geographic designation, but both the Vancouver and Portland areas are not considered over utilized by federal standards

4. The North County Area (Yacolt – Ridgefield) can be designated for the entire population (Geographic) as there are no primary care physicians and nearby areas are over utilized by Federal definitions.

5. We can not update the existing downtown designation because of changes in poverty data disqualify the area. We looked at several designation configurations in our analysis. Only two options for reconfiguring the Downtown Vancouver Area Designation would be likely to meet Federal Criteria

    a. A Low-Income Homeless Designation for the down-town core and industrial areas along the river (Riverside). The area and population designated would be significantly smaller than the existing designation. There is only one clinic (Vancouver Medical Clinic at 2211 E Mill Plain Blvd) in this area and it has very high poverty levels (57% of the population over 200% of FPL). The advantage of this approach is that it would focus resources on only the very highest areas of need and it would be a very straightforward designation with an extremely high likelihood of being approved.

    b. A Low-Income Homeless Designation for Vancouver/Hazel Dell. This is an area which is larger than the existing designation and corresponds to the Vancouver and Hazel Dell areas. This designation covers both SeaMar and the clinics surrounding Southwest Medical Center. This area has a moderate poverty level (32% which exceeds Federal requirements) and the shortage ratio is 4028:1. The advantage of this approach is that it confers eligibility to a much larger area and to more practices. The disadvantage is that it is a more complex case to make and that while the area would still be eligible for National Health Service Corp (Loan and Scholarship recipients) -- the area would not be as a competitive for NHSC scholars which are awarded competitively on the basis of need.

Designation Options and Program Eligibility for Clark County

			Vancouver Options	
Programs	North County	Camas	Riverside/Core	Vancouver Hazel Dell
Rural Health Clinic status	Eligible	Not Applicable	Not Applicable	Not Applicable
Medicare Bonus Payment	Eligible	Not Eligible	Not Eligible	Not Eligible
NHSC	High Score	High Score	High Score	Low Score
J-1 Visa Waiver	Eligible	Eligible	Eligible	Eligible
Medicare Telemedicine	Eligible	Not Eligible	Not Eligible	Not Eligible
CMHC	Higher Score	Higher Score	Higher Score	Higher Score
Criteria				
Population	20984	11858	34537	182945
Provider: Low Income Population Ratio	No Providers	12,592:1	240,000:1	4028:1
% 200% of FPL	22%	30%	57%	32%
Likelihood of Approval	Very High	Moderate	Very High	Moderate

The major trade-off between the two Vancouver options is breadth of the area covered (and number of existing Clinics) versus "risk" in the approval process. Existing clinics that are located in the proposed Vancouver/Hazel Dell designation are listed on the next page

The risk in the approval is very moderate. In the event that the Federal Shortage Designation Branch at HRSA/DHHS does not approve a designation request we can resubmit a revised application. So the risk is one of delay – not "all or nothing". The only other reason for pursing the Riverside/Core Option would be if there were specific plans to expand Federally Qualified Health Center services and capacity in this area.

Clinics covered in Option B

Census Tract	Office	Number of Physicians	Specialty	Address	City	Zip Code	
410.02	David L. Dixon, MD	1	FP	6108 NE Hwy 99, Suite 108	Vancouver	98665	36
412.03	Family Physicians Group Inc. PS, Mer	9	FP	100 E. 3rd St., Suite 100	Vancouver	98663	36
412.05	Evergreen Pediatric Clinic	8	GPEDS	8614 E. Mill Plain Blvd	Vancouver	98661	36
	Family Medicine Southwest	7	FP	8614 E. Mill Plain Blvd	Vancouver	98661	36
	Family Medicine Southwest	2	GIM	8716 E. Mill Plain Blvd	Vancouver	98661	36
	Family Medicine Southwest	19		8716 E. Mill Plain Blvd	Vancouver	98661	36
	McLoughin Family Practice Group	3	FP	505 NE 87th Ave Suite 160	Vancouver	98664	36
	Mill Plain Family Medical	1	FP	411 NE 87th Ave	Vancouver	98682	36
	Sea Mar Community Health Center	4	FP, GIM	407 NE 87TH Ave	Vancouver	98664	36
	The Vancouver Clinic - 87th Ave	15	GIM	505 NE 87TH Ave, Suite 102	Vancouver	98664	36
	The Vancouver Clinic - 87th Ave	7	GPEDS	505 NE 87TH Ave, Suite 102	Vancouver	98664	36
	The Vancouver Clinic - 87th Ave	7	OB/GYN	505 NE 87TH Ave, Suite 102	Vancouver	98664	36
	The Vancouver Clinic - 87th Ave	2	FP	505 NE 87TH Ave, Suite 102	Vancouver	98664	36
	The Women's Clinic of Vancouver, P.S	5	OB/GYN	505 NE 87TH Ave, Suite 260	Vancouver	98664	36
041313	Ashford Medical	1	GIM	5512 NE 107 Ave	Vancouver	98662	36
041318	Cascade Park Medical Office	8	FP	12607 SE Mill Plain Blvd	Vancouver	98684	36
	Cascade Park Medical Office	6	GIM	12607 SE Mill Plain Blvd	Vancouver	98684	36
	Cascade Park Medical Office	4	GPEDS	12607 SE Mill Plain Blvd	Vancouver	98684	36
	Northwest Medical Associates, PS	5	GIM	315 SE Stonemill Dr, #20	Vancouver	98684	36
413.22	Cascade Family Medicine	2	FP	406 B SE 131 Ave, Suite 203	Vancouver	98683	36
	Cascade Park Internal Medicine (Adventist Health)	2	GIM	406 - A SE 131 Ave, Suite 104	Vancouver	98683	36
419	Hudson's Bay Medical Group	5	GIM	100 East 33rd St, Suite 206	Vancouver	98663	36
426.00	Vancouver Medical Office	4	FP	2211 E Mill Plain Blvd	Vancouver	98661	36
	Vancouver Medical Office	4	GIM	2211 E Mill Plain Blvd	Vancouver	98661	36
	Vancouver Medical Office	1	GPEDS	2211 E Mill Plain Blvd	Vancouver	98661	36
431.00	Carulli Medical Clinic	1	GIM	304 N. Lieser Rd	Vancouver	98664	36
	Total	133					

[i] Office of Financial Management, 2003. Washington State Data Book. County Profiles at http://www.ofm.wa.gov/databook/county/index.htm

[ii] Office of Financial Management, 2003. State and County Population Ages 65 and Over: 1980-2003 at http://www.ofm.wa.gov/pop/pop65/index.htm

[iii] Schueler, V. Washington's Primary Care Safety Net: Structure and Availability. Office of Community and Rural Health, August 18, 2004. Available at URL: http://www.doh.wa.gov/hsqa/ocrh/har/hcresrch.htm.

[iv] Fox DM Fronstein P. Public spending for health care approaches 60%. Health Affairs. 19(2). March April 2000.

[v] Employment Security Department. 2000 Labor market information by county. Olympia (WA): Employment Security Department [cited May 2002]. Available from URL: http://www.wa.gov/esd/lmea/labrmrkt/byarea.htm .

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[vii] Office of Financial Management. Washington state planning grant on access to health insurance: HRSA progress report. Olympia (WA): Office of Financial Management, 2002, March, p 17. Available from URL: http://www.ofm.wa.gov/accesshealth/reports/progress/0302progress.htm

[viii] Office of Financial Management, 2003. Preliminary Intercensal Population Estimates for 1990 to 2000 with Estimates for 2001 to 2003 at http://www.ofm.wa.gov/pop/april1/index.htm

[ix] Number of Medical Assistance Administration Enrollees, 9/2004, available from URL: http://fortress.wa.gov/dshs/maa/Eligibility/countofeligiblesbyprogram.html, Divided by OFM 2004 population estimates, available at URL: http://www.ofm.wa.gov/pop/april1/finalpop2004.xls

[x] Department of Social and Health Services, Research and Data Analysis Division. Residents Receiving DSHS Services: SY 2002 By County. Available March 2004 from: http://www1.dshs.wa.gov/rda/research/clientdata/2002/default.shtm

[xi] Schueler V. Health care services. In The Health of Washington State. Olympia(WA): Washington Department of Health, forthcoming. Available June 2002 from: URL http://www.doh.wa.gov/

[xii] Center for Medicare and Medicare Services: Medicare Managed Care Enrollment statistics for March 2004 [cited July 2004] Available from: URL: Source: http://www.cms.hhs.gov/healthplans/statistics/mpsct/

[xiii] The Urban Institute. State ressponses to Budget Crisis in 2004: An Overview of Ten States - Overview and Case Studies . State and local initiatives to enhance health coverage for the working uninsured. New York: Kaiser Family Foundation January 2004 Available from: URL: http://www.kff.org/medicaid/7002.cfm